

Mail To:

E.D.S. FEDERAL CORPORATION  
Prior Authorization Unit  
Suite 88  
6406 Bridge Road  
Madison, WI 53784-0088

**PA/AA**

**PRIOR AUTHORIZATION  
AODA SERVICES ATTACHMENT**

1. Complete this form
2. Attach to PA/RF  
(Prior Authorization Request Form)
3. Mail to EDS

**RECIPIENT INFORMATION**

① [ ] LAST NAME	② [ ] FIRST NAME	③ [ ] MIDDLE INITIAL	④ [ ] MEDICAL ASSISTANCE ID NUMBER	⑤ [ ] AGE
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**PROVIDER INFORMATION**

⑥ [ ] PERFORMING PROVIDER'S NAME AND CREDENTIALS	⑦ [ ] PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ [ ] PERFORMING PROVIDER'S TELEPHONE NUMBER
⑨ [ ] REFERRING/PRESCRIBING PROVIDER'S NAME	⑩ [ ] REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER	

**PART A**

**TYPE OF TREATMENT REQUESTED:**

☐ **PRIMARY INTENSIVE OUTPATIENT TREATMENT**

- ☐ Individual    ☐ Group    ☐ Family
- Number of minutes per session: \_\_\_\_\_ Individual    \_\_\_\_\_ Group    \_\_\_\_\_ Family
- Sessions will be: ☐ Twice/month    ☐ Once/week    ☐ Once/month    ☐ Other (specify) \_\_\_\_\_
- Requesting \_\_\_\_\_ hrs/week, for \_\_\_\_\_ weeks
- Anticipated beginning treatment date \_\_\_\_\_
- Estimated intensive treatment termination date \_\_\_\_\_
- Attach a copy of treatment design, which includes the following:
  - (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
  - (b) Description of aftercare/follow-up component

☐ **AFTERCARE/FOLLOWUP SERVICE**

- ☐ Individual    ☐ Group    ☐ Family
- Number of minutes per session: \_\_\_\_\_ Individual    \_\_\_\_\_ Group    \_\_\_\_\_ Family
- Sessions will be: ☐ Twice/month    ☐ Once/week    ☐ Once/month    ☐ Other (specify) \_\_\_\_\_
- Requesting \_\_\_\_\_ hrs/week, for \_\_\_\_\_ weeks
- Estimated discharge date from this component of care \_\_\_\_\_

☐ AFFECTED FAMILY MEMBER/CO-DEPENDENCY TREATMENT

- ☐ Individual    ☐ Group    ☐ Family
- Number of minutes per session: \_\_\_\_\_ Individual    \_\_\_\_\_ Group    \_\_\_\_\_ Family
- Sessions will be: ☐ Twice/month    ☐ Once/week    ☐ Once/month    ☐ Other (specify) \_\_\_\_\_
- Requesting \_\_\_\_\_ hrs/week, for \_\_\_\_\_ weeks
- Anticipated beginning treatment date \_\_\_\_\_
- Estimated affected family member/co-dependency treatment termination date \_\_\_\_\_
- Attach a copy of treatment design, which includes the following:
  - (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
  - (b) Description of aftercare/follow-up component

**PART B**

1. Was the recipient in primary AODA treatment in the last 12 months?    ☐ Yes    ☐ No    ☐ Unknown

If "yes," provide dates, problem(s), outcome and provider of service:

2. Dates of diagnostic evaluation(s) or medical examination(s):

3. Specify diagnostic procedures employed:

4. Provide current primary and secondary diagnosis (**DSM-III**) codes and descriptions:

5. Describe the recipient's current clinical problems and relevant history; include AODA history:

6. Describe the recipient's family situation; describe how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

7. Provide a detailed description of treatment objectives and goals:

8. Describe expected outcome of treatment (include use of self-help groups if appropriate):

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**Recipient Authorization**

9. I have read the attached request for prior authorization of AODA services and agree that it will be sent to the Medicaid Program for review.

<hr/> <p style="text-align: center;">Signature of Recipient or Representative (If representative, state relationship to recipient)</p>	<hr/> <p style="text-align: center;">Relationship</p>
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Attach a photocopy of the physician's prescription for treatment. The prescription must be signed and dated within 3 months of receipt by EDS (initial request) or within 12 months of receipt by EDS (subsequent request). (Physician providers need not attach a prescription unless treatment is prescribed by another physician).

**THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).**

10.

<hr/> <p style="text-align: center;">Signature of Performing Provider</p>	<hr/> <p style="text-align: center;">Discipline of Performing Provider</p>
<hr/> <p style="text-align: center;">Name of Supervising Provider</p>	<hr/> <p style="text-align: center;">Provider Number of Supervising Provider</p>
<hr/> <p style="text-align: center;">Signature of Supervising Provider</p>	<hr/> <p style="text-align: center;">Date</p>